Re:
Barnes, et al.,
vs.
The American Tobacco Company, et al.
August 6, 1997
Deposition of THOMAS MORGAN HYERS, M.D., Volume I
In the United States District Court
For the Eastern District of Pennsylvania
Barnes, et al.,
Plaintiffs,
vs. Civil Action No. 96-5903-CN
The American Tobacco Company,
et al.,
Defendants.
Volume I
Deposition of THOMAS MORGAN HYERS, M.D., taken on behalf of the Defendants Lorillard and Brown & Williamson Tobacco Companies, at the offices of St. Louis University Hospital, Seventh Floor, Department of Pulmonology, 3635 Vista Avenue in the City of St. Louis, State of Missouri, between 1:15 P.M. and 4:25 P.M. on the 6th day of August, 1997, before J. Bryan Jordan, Certified Court Reporter and Notary Public.
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THOMAS MORGAN HYERS, M.D.,

of lawful age, having been first duly sworn to testify the truth, the whole truth, and nothing but the truth in the case aforesaid, deposes and says in reply to oral interrogatories propounded as follows, to-wit:

EXAMINATION

QUESTIONS BY MR. FOWLER:

Q. All right, Doctor, my name is Greg Fowler. I'm here representing Lorillard Tobacco Company and Brown & Williamson in a case that's formally known as the Arch case; now it's been restyled the Barnes case. Do you understand that you are here to give your deposition in that case, sir?

A. Yes.

Q. Okay. Would you please state your full name, business address, and position for the record?

A. Thomas Morgan Hyers. I'm a physician. I'm a Professor of Internal Medicine at St. Louis University School of Medicine, 3635 Vista Avenue at Grand Boulevard, St. Louis, Missouri, 63110.

Q. And your full position is what, sir?

A. Professor of Internal Medicine.

Q. Now, have you had your deposition taken before?

A. Yes, I have.

Q. On approximately how many times?

A. I would say scores.

Q. Scores of times. Well, let me just briefly, then, review what I call the rules of the road, so we can establish our framework for the deposition today.

First of all, the deposition will be taken in question-and-answer format, and you understand that, don't you?

A. I do.

Q. And the court reporter will be taking down what we say verbatim, so it will be necessary for us to talk one at a time. You'll need to let me finish a question before you start talking, I'll need to let you finish your answer before I start talking. Is that acceptable to you?

A. Yes.

Q. Okay, great. Is there any reason, as you sit here today, that you can't understand my questions or truthfully and fully respond to those questions?

A. I can think of no reason.

Q. In other words, you are not suffering from

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undue fatigue or under some particular kind of medication or something, are you?
A. I am not.
Q. Okay. Sir, do you have any felony convictions?
A. No.
Q. Have you ever been reprimanded by a medical or scientific body?
A. No.
Q. Are there any ongoing criminal investigations involving yourself?
A. No.
MR. FOWLER: Let's mark this as the first exhibit, please.
(Deposition Exhibit Dr. Hyers Dr. Hyers 1 marked for identification.)
BY MR. FOWLER:
Q. Doctor, I'm going to hand you what's been marked Deposition Exhibit Number 1, and tell you that it's a notice of deposition, and ask you if you've ever seen a copy of that before.
A. I believe I have.
Q. Under what circumstances did you receive a copy of that?
A. It came to me. I don't know how it got here, but I believe I did see that.
Q. Okay. You'll see in the last paragraph, on the first page, that you are asked to bring a number of materials, are you not, to the deposition?
A. Yes.
Q. What's the first item on that, sir?
A. A copy of my CV.
Q. Have you brought that with you today, sir?
A. I have.
Q. May I have a copy of that, please?
(Witness complies.)
Q. (Continuing) Do you have multiple copies there, sir?
A. Yep.
Q. Might I take two?
A. Help yourself --
Q. Okay.
A. -- to all of the ones on the table.
Q. All right. Doctor, what's the second item listed there on the notice of deposition?
A. A copy of the expert report.
Q. And have you brought that, sir?
A. Yes, I have.
Q. And then what does it say? Does it ask for a copy of your expert report with attachments or something?
A. With all attachments.
Q. Okay, and were you able to bring the attachments to that, as well?
A. The only attachment I'm aware of is what's stapled on to the back, there.
Q. Okay, and then what's item number 2, there, in Exhibit Number 1, sir?
A. "All documents upon which he relied in preparing his expert report."
Q. And that "he" is you, isn't it?
A. That's me.
Q. And did you bring those materials, sir?

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A. I did not. That's textbooks, it's papers, it's all sorts of things. I mean, it would be anything I'd read about this matter for the last twenty or thirty years.

Q. "This matter" being what, sir?

A. The matter of cigarette smoking and disease.

Q. So everything that you've read concerning cigarette smoking and disease is relevant to the development of your expert report?

A. I believe it is, yes.

Q. What's the next item?

A. "All documents which he read, reviewed, or consulted in preparing his expert report in this action, including any documents related to this action."

Q. And did you bring documents that were responsive to that request?

A. I have them in my office right down the hall. I can get them for you.

Q. Why don't you go ahead and do that for me, sir.

MR. HUTTON: Wait. Can I have the question read back? I just want to make sure that we're consistent with the working understanding that you Pennsylvania lawyers have entered into in this case. I understand that -- I think it was you, Mr. Fowler, that wanted to make sure that contacts between the counsel and the expert is not discoverable, --

MR. FOWLER: Oh.

MR. HUTTON: -- and I don't recall what the question was, per se, but if we're getting into communications, contact, materials that he may have reviewed at the request of Pennsylvania counsel, I think, according to the understanding that you gentlemen have, it's not discoverable, and I know you want the rules to be applied both sides --

MR. FOWLER: You are precisely right. I'd like to have the rules applied squarely on both sides, but I tried to get Mr. Sheller to agree with that, that arrangement and he wouldn't do so, so --

MR. HUTTON: Well, I think he was --

MR. FOWLER: He said he couldn't speak for the other lawyers in the case.

MR. KLEIN: He didn't get back to anyone.

MR. HUTTON: Right. Well, I don't know if he did or not. He was going to, whether he did or not.

MR. KLEIN: He didn't.

MR. FOWLER: But if you can make the agreement that nothing that's communicated between lawyers and their witnesses that would be considered work product, if you are agreeable to that rule applying to every deposition in this case and you can make that representation on the record, have at it; we'll do it.

MR. HUTTON: I'm not in a position to make any representations on behalf of the other Pennsylvania lawyers.

MR. FOWLER: Okay. Then we'll need to have this whole case filed -- you can go ahead and read back the question. I don't think it asked for anything, but we'd like to have the case --

MR. HUTTON: Are you putting on the record that you believe that the communications that you have

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with your experts when they're deposed or they're in the courtroom, it's fair game for open discovery?

MR. FOWLER: Well, I think that the rules of attorney-client privilege and attorney work product would have to be taken into consideration, and to the extent that those rules apply, they apply.

MR. HUTTON: What limited knowledge I have is there's certain law, they tell me that there is a work product protection that affords counsel the opportunity of freely discussing matters with experts without having the matters discussed or subject to discovery.

MR. FOWLER: Well, what I'd like to do, then, just to speed things up, I'm sure that the Philadelphia lawyers have a view as to what the Pennsylvania law is, and I'm certainly not aware of it, but if you wouldn't mind accompanying the witness and taking a quick look through his case file, and then bring me what, what you are not going to object to --

MR. HUTTON: Let me find out what exactly was the question? I mean, are you --

MR. FOWLER: I can restate the question so we don't have to have the court reporter go back. I'm referring to the request in number 5 -- I'm sorry, number 4, of document Exhibit Number 1, which asks the doctor to provide all documents which he read, reviewed, or consulted in preparing his expert report in this action, including any documents relating to the action. The doctor told me he had a case file that he could get for me, and that's what I'd like to have.

MR. HUTTON: Let me see that, if I could.

MR. KLEIN: I also believe the discussion with Mr. Sheller regarding work product did not relate to materials provided but simply related to conversations he may have had with the expert witness, so -- and frankly, Dr. Petty, at his deposition, just so you know, Mark, he produced his entire case file at that deposition, without objection from Steve.

MR. FOWLER: Yeah, including materials that --

MR. KLEIN: That were sent to him by Steve.

MR. HUTTON: Okay. We'll momentarily adjourn and go and see what he has insofar as what documents he may have read, reviewed, consulted in preparation of his expert report. We'll momentarily adjourn and see what he's got here. As long as the rules apply equally.

(Pause.)

MR. HUTTON: Let me make a little record, here, Mr. Fowler. Are you saying that Deposition Exhibit Number 1 -- that is the what I call the duces tecum notice for the expert to bring certain documents to his deposition -- will be applied when Plaintiffs' counsel deposes the Defendants' experts?

MR. FOWLER: Yeah.

MR. HUTTON: Okay. With that understanding --

MR. WEIL: Subject to the applicable rules.

MR. FOWLER: Subject to any applicable objections, but --

MR. HUTTON: Well, if you want the enforcement of this duces tecum to be used on this expert, it should be equally enforced --

MR. FOWLER: If you use the same language

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that we use here, then I don't see any problem with that.
MR. HUTTON: Okay.
MR. FOWLER: That's what I'm trying to say; okay?
MR. HUTTON: Get what you want here. There it is.
MR. FOWLER: Okay. Why don't we go ahead and take a moment and let's mark Dr. Hyers' CV as Deposition Exhibit Number 2, and then what's been -- what is titled "Early Identification and Intervention in Smoking-related Diseases, the Importance of Medical Monitoring," that's Dr. Hyers' report in the case, we'll mark that as Deposition Exhibit Number 3, please.

(Deposition Exhibit Dr. Hyers 2 and 3 marked for identification.)

BY MR. FOWLER:

Q. Doctor, I'm going to place in front of you just for the moment, Doctor, for identification purposes let me hand you what's been marked as Deposition Exhibit Number 2 and ask you to identify that, please.

A. It's a copy of my curriculum vitae.

Q. Is that current up to the present date?

A. Yes.

Q. Are there any additions, or deletions, or other changes that would be necessary to make it completely accurate?

A. No.

Q. And it's accurate as it sits there in front of you?

A. Yes.

Q. Great. Then let me have you identify, please, what's been marked as Deposition Exhibit Number 3.

A. You want me to identify this?

Q. Yes please, sir.

A. It's a report prepared by Dr. Thomas Petty and myself entitled "Early Identification and Intervention in Smoking-related Diseases: The Importance of Medical Monitoring."

Q. Is that your report in this case, sir?

A. That's correct.

Q. And is there anything necessary, as you sit here today, to correct any inaccuracies, to update or to otherwise make it acceptable to you?

A. There's only one thing that I would argue about in this report.

Q. What's that, sir?

A. On page 5, the first paragraph, I believe the statement is somewhat inaccurate, starting with the sentence, "Approximately equal numbers of men and women are smoking today, and it is now known that the threshold for carcinogenesis in the lung requires 20 or more pack-years of smoking." I do not believe that "threshold" was the correct word, there, that we meant to use.

Q. What word did you mean to use?

A. What we meant to say was that the risk greatly increases after 20 pack-years, but I don't believe that the word "threshold" is the appropriate word.

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Q. Now, what is it that prompted your focussing on that particular portion of your expert report?
A. Because I've read this and I've read Dr. Petty's deposition, which called my attention to it.
Q. You think Dr. Petty's testimony on that point was inaccurate?
A. Dr. Petty will have to speak for himself. I think he or I meant to imply that you couldn't get lung cancer if you had smoked less than twenty pack-years.
Q. The language speaks for itself, though; right?
A. That's the way it's written at that time, yes.
Q. Okay, and as you sit here today, do you disagree with Dr. Petty's testimony in that point during his deposition?
A. I'd have to review his particular testimony to tell you what I agree with and what I disagree with, but I do believe that the implication that one can't get lung cancer with less than twenty pack-years is incorrect.
Q. Tell me how you would explain that more accurately.
A. I would say that the risk of lung cancer is dose-related to the amount of smoking and the length of time of smoking, and the longer one smokes, the more likely one is to get lung cancer.
Q. Is there at some point in one's smoking history that they're not at a statistically increased risk of contracting -- let's take lung cancer, for example, as a result of their smoking?
A. It's a dose-related event, so yes, you could find, across populations, a point early on where the statistical risk would not be significant.
Q. Are you familiar with recent literature, a 1996 publication, that suggests that people who have a 20-year smoking history of 10 cigarettes or less are not at a statistically increased risk of contracting lung cancer?
A. You'd have to show me the paper. I can't tell you I'm familiar with it off the top of my head. I've already testified that there is a dose-related relationship.
Q. Right, and what I'm trying to get from you, then, is what your understanding of that dose relationship, at what point in one's smoking history are they at a statistically increased risk of contracting lung cancer.
A. Again, these, these numbers are derived over populations. We can't really make these statements for an individual. We can make the statement from a population. We chose 20 pack-years as a good starting point for increased risk for screening, but we've all seen individuals who have developed lung cancer with less smoking.
Q. And you've seen many individuals who have not contracted lung cancer with greater smoking history; correct?
A. We've seen individuals smoke longer than that and not develop lung cancer, that's correct.
Q. And so what I'm asking you to do, even if it is simply across populations, rather than with regard to a particular individual, I'm asking you if you'll

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give me today, as you sit here, that threshold.
A. I don't recognize a threshold for an individual. I'm unable to tell you what the threshold is.
Q. There is one, but you don't know, as you sit here today, what it is?
A. I don't know what there is for a particular individual. It probably varies by individual.
Q. But I suppose my question is, can you give me a threshold that would hold across populations as a population statement, rather than an individual assessment?
A. I can give you a starting point for screening high-risk people, which is what we meant by choosing 20 pack-years. I would not refer to it as a threshold.
Q. So that's a thresh--let's not use the "threshold" word, then, for the purposes of this question. Your statement, if I understand it correctly -- please correct me if I'm wrong -- is that when you said "threshold," there, in your expert report on page 5, what you meant to suggest was that that's the point at which there is a significant enough risk that monitoring ought to be undertaken for asymptomatic smokers; is that correct?
A. Across populations, that is correct.
Q. Are you familiar with literature that suggests that people who smoke four to five cigarettes a day for smoking lifetime are not at a statistically increased risk of contracting lung cancer?
A. In any sort of risk factor, with a dose-response relationship, people with low smoking histories would be at sufficiently less risk that some might not statistically be liable to develop lung cancer. I think that, that also goes to the whole issue of passive smoking, which has been difficult to prove as a carcinogen.
Q. Is there anything else in your expert report that requires correction or clarification?
A. That's all.
Q. And you are happy with it, then, as it sits there in front of you, that it accurately reflects the medical monitoring program that you think would be appropriate in connection with Philadelphia -- I'm sorry, Pennsylvania residents; correct?
A. I believe it does.
MR. FOWLER: Thank you. Now, let's go and take a look at your case file, now, that you brought into the deposition room just a few moments ago.
What I would like to do is mark this as a group exhibit, please. Let's just mark this as Number -- this is clever -- Number 4.
(Deposition Exhibit Dr. Hyers 4 marked for identification.)
BY MR. FOWLER:
Q. I'm handing you what's been marked Deposition Exhibit Number 4, and I'd ask you if you would be so kind, sir, to identify that for me.
A. These are the papers, the scientific and medical papers that I reviewed in the process of helping to prepare our report.
Q. And that's the report that's Deposition Exhibit Number 3; correct?
A. That's correct.

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Q. Let me hand you again Deposition Exhibit Number 3, and at page -- beginning at page 9, there's a reference, references section; is that correct?
A. Correct.
Q. And t here's 24 references; correct?
A. Correct.
Q. Some of those have check marks in front of those; did you make those check marks?
A. I did.
Q. For what reason?
A. Because those were reports that I wanted to review in the process of preparing this expert report.
Q. Where did that list of references come from?
A. I believe Dr. Petty prepared that list of references initially.
Q. And then from that list of references that Dr. Petty prepared, you checked off the ones that you wished to review; correct?
A. Correct.
Q. Okay. By what criteria or criterion did you select those articles?
A. I selected those articles because I thought they were pertinent to the issue of screening and medical monitoring.
Q. Did you do any other research to identify additional articles that might be pertinent to the issue of medical monitoring in this case?
A. No.
Q. So you relied exclusively on this sheet of references for those such materials?
A. Well, as I said, I have been studying and involved in this area for twenty or twenty-five years, but in the preparation of this report, those are the references that I specifically read.
Q. Have you been involved in medical monitoring issues as they relate to smoking for that complete period of time that you just referred to?
A. No.
MR. HUTTON: Let me object to the vague use of the word "medical monitoring issues." I mean, personally, the care and treatment of one patient arguably could be medical monitoring, so I think unless we get a better clinical understanding of what you mean by medical monitoring, the answer you elicit may be a little misleading and inaccurate.
BY MR. FOWLER:
Q. Doctor, anytime I ask you a question that is misleading, is vague, you are unhappy with for whatever reason, will you please tell me, and I'll go ahead and ask you another question, or rephrase it, or so forth. Is that okay?
A. I will.
MR. FOWLER: Maybe one of the Pennsylvania lawyers can inform Mr. Hutton about the rules against speaking objections in the Barnes case.
MR. KLEIN: There aren't any.
MR. FOWLER: There aren't any speaking objections; correct?
MR. KLEIN: Correct. That's in the case management order.
MR. FOWLER: And so if we can -- because I know Mr. Hutton is a stickler for rules; we discussed that earlier, and I know that now that he knows that

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rule, he will adhere to it vigorously. Am I right?
MR. HUTTON: There are no rules regarding speaking objections? Is that what I just heard?
MR. FOWLER: No, the rule is there are no speaking objections, and so I'll have your agreement that you'll adhere to that rule, don't I, or can't I?
MR. HUTTON: I'll just agree that I'll be a lawyer and best representing these poor victims of smoking, so --
MR. FOWLER: And you'll subject yourself to the jurisdiction of the Pennsylvania District Court in case the Court disagrees with your interpretation of the case management order?
MR. HUTTON: I'm an officer of the Court; I'll be a good little boy.
BY MR. FOWLER:
Q. Now, Doctor, in addition to the materials we've marked as exhibits, you've brought with you other materials to the deposition. Can you identify those materials for me, please?
A. I have some other communications from the group that we're referring to as the Philadelphia lawyers.
MR. FOWLER: Not these, not the Philadelphia lawyers sitting here at the table, but other lawyers like Mr. Sheller; is that correct?
MR. KLEIN: It's a term of honor.
MR. HUTTON: Of honor?
MR. KLEIN: That's correct.
A. You want me to identify them?
BY MR. FOWLER:
Q. Yes, please.
A. One is a fax May 6, '9, from Bob LaRocca, identifying a sketch of a medical monitoring, potential medical monitoring program.
Q. Did you receive that before you prepared your expert report?
A. I received it in the process of preparing it. I can't tell you precisely when; it would have been early.
Q. It's May 6th, there, at the top; is that correct?
A. Correct.
Q. And your expert report was signed on May 23rd; is that correct?
A. Correct.
MR. FOWLER: Okay. Let's mark this as Deposition Exhibit Number 5.
(Deposition Exhibit Dr. Hyers 5 marked for identification.)
BY MR. FOWLER:
Q. What's the next item there, sir?
A. The next item is a, another fax dated 5-22-97, from, I believe, Mr. Sklaroff, again with some information about a medical monitoring program.
Q. And you actually received that, then, the day before you signed your expert report; correct?
A. I believe that's correct.
Q. May I take a look, sir?
A. Sure.
MR. FOWLER: Thank you. Why don't you go ahead and mark that as the next numbered exhibit, please.

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(Deposition Exhibit Dr. Hyers 6
marked for identification.)

BY MR. FOWLER:

Q. Doctor, you received Exhibit Number 6 from Dr. Sklaroff? Is that correct?

A. His name is on the origin of the fax. I believe it came from him.

Q. Who is Dr. Sklaroff?

A. Dr. Sklaroff is the physician in Pennsylvania who has been working with the Plaintiffs in this matter.

Q. Have you had contact with Dr. Sklaroff outside of this fax transmission?

A. By telephone.

Q. How many times?

A. We had several conference calls; somewhere between 3 and 5, as I recall.

Q. We'll get into that a little more later, then.

And what's the next item, sir?

A. This is a protective order in what was then called Arch, et al., vs. American Tobacco. It looks like a court document.

Q. Do you know why you received this?

A. No.

Q. Do you know from whom you received this?

A. Is there a fax --

Q. I don't believe so.

A. I can't tell you who sent it to me.

MR. FOWLER: Let's mark this as the next exhibit, please.

(Deposition Exhibit Dr. Hyers 7
marked for identification.)

BY MR. FOWLER:

Q. And what's the next item in front of you, sir?

A. A fax dated May 15th, '97, from the law firm of Mellon, Webster & Mellon.

Q. What does that regard?

A. It regards, I believe, the names of individuals who were involved in this matter for the Plaintiff, experts and other individuals.

Q. Do you know the purpose for which you received this communication?

A. Other than just general information, I can't tell you.

MR. FOWLER: Let's mark this as the next numbered exhibit, 8.

(Deposition Exhibit Dr. Hyers 8
marked for identification.)

BY MR. FOWLER:

Q. And what's the next item in front of you there, sir?

A. A fax from Mellon, Webster & Mellon, dated May 23rd, '97.

Q. What does that regard?

A. It regards cost analysis of various screening methodology.

Q. And you received that on the day that you signed your expert report; correct?

A. I believe that's correct.

Q. Did you give this any consideration in preparing or finalizing your expert report?

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A. No.
Q. Do you know why you received this?
A. Again, I think just for general information.
Q. And this appears to be a letter to Tom, Thomas Mellon from Jerome M. Staller, S-t-a-l-l-e-r, and Edward A. Friedman, F-r-i-e-d-m-a-n, who appear to be with the Center For Forensic Studies; is that correct?
A. I believe that's right.
Q. Do you know who they are?
A. I don't know these individuals personally.
Q. And the front of this is entitled "New Friedman Report," correct?
A. Correct.
Q. Was there an old Friedman report?
A. It went through several drafts.
Q. Did you see those drafts?
A. I may have seen some of them.
Q. Did you comment on or provide input concerning any of those drafts?
A. Not really.
Q. When you say "Not really," is that a "no" or is that a "sort of"?
A. Well, in the course of telephone conversations, I may have made one or two comments, but I don't believe I had any substantial input into the cost analysis of various screening methods.
Q. Do you have an expert opinion concerning the cost of the screening program that's proposed in your expert report?
A. I believe what we are proposing is reasonable and cost effective.
Q. But I'm not asking to you characterize it, I'm asking you whether you have an idea how much it would cost.
A. I don't know.
Q. Does it matter?
A. It would depend on how many people are screened, obviously.
Q. Does it matter to you how much it would cost?
A. I wouldn't want to propose methodology that was terribly expensive. Yes, it does matter.
MR. FOWLER: Could you mark this as the next numbered exhibit, please? And let me just continue, if I could, and the "this" I just refer to is the May 23rd, 1997, report of the Center For Forensic Studies.
(Deposition Exhibit Dr. Hyers 9 marked for identification.)
BY MR. FOWLER:
Q. We just emptied out the second folder, but you have a number of other papers that you brought with you to the deposition today; is that correct?
A. That's correct.
Q. And let's identify those materials, as well, sir.
(Discussion off the record.)
BY MR. FOWLER:
Q. (Continuing) We're back on the record now, and Doctor, you are going to identify the remaining that materials that you brought with you to the deposition today.
A. I brought copies of two abstracts that pertain to medical monitoring programs that we've run,

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here, with asbestos-exposed individuals, as well as a list of the testimony I've given in deposition and at trial since 1991, I believe.

Q. And if I can --

A. There's a copy for everybody.

Q. Oh, I see. I've got you, and Doctor, if you could, just identify with a little particularity what each of these are.

MR. FOWLER: In fact, let's, just for identification purposes, mark those first as 10 and 11.

(Deposition Exhibits Dr. Hyers 10 and 11 marked for identification.)

BY MR. FOWLER:

Q. (Continuing) And Doctor, I'm going to hand you what's been marked as Deposition Exhibit Number 10 and ask if you wouldn't mind identifying that for me, please.

A. This is an abstract that we presented at the American Thoracic Society Conference in 1996 regarding factors that influence the progression on chest x-ray of asbestos-induced lung disease.

Q. And why did you bring that with you to the deposition today? What relevance does it have?

A. I brought it because it pertains to the issue of medical monitoring, as well as to the issue of smoking.

Q. And then let me hand you what's been marked as -- oh, did -- before I ask that question, has Deposition Exhibit Number 10 led to, or have you published an article relating to the same topic?

A. The paper's in preparation, has not yet been submitted.

Q. Let me hand you Deposition Exhibit Number 11 and ask you to identify that, too, please.

A. This is an abstract relating to the effect of physician counseling and various factors in the health screening finding, findings, on whether or not a person continues to smoke or not with asbestos exposure.

Q. Were you involved in the preparation of this abstract?

A. Yes.

Q. And then the last item you brought with you was what, sir?

A. Listing of deposition and court testimony since 1991.

MR. MURPHY: Doctor, do you have multiple copies of that, too?

MR. FOWLER: Let's mark this as Exhibit Number 12, please.

(Deposition Exhibit Dr. Hyers 12 marked for identification.)

BY MR. FOWLER:

Q. Are there any documents that you had in your case file or other materials that you had intended to provide us today that you didn't provide at the instruction of your lawyer, here, today, or not your lawyer, but Mr. Hutton today?

A. No.

Q. And did you hand Mr. Hutton any documents today to review when you got together before this deposition?

A. We reviewed these documents and -- we

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reviewed a number of documents in my office.
Q. Did you review any documents in your office that haven't been marked as exhibits here today?
A. Yes, we did.
Q. What did you review?
MR. HUTTON: Well, I thought we had this understanding that communications between counsel and the expert is not discoverable.
MR. FOWLER: I'm not sure we do have that understanding. I mean, you couldn't give me that understanding, Sheller couldn't give me that understanding, and I don't think we had an understanding.
MR. HUTTON: Okay. Well, I'm under instructions not to allow that type of inquiry, so --
MR. FOWLER: Are you instructing the witness not to answer the question?
MR. HUTTON: I can't do that.
MR. FOWLER: I know, so I'm going to ask him the question, and then he's either going to answer it or we're going to have a problem.
MR. HUTTON: I'm not going to tell him not to answer. I'm going to respectfully suggest he not answer the question, based my understanding of the Third Circuit law.
BY MR. FOWLER:
Q. (Continuing) Doctor, would you please identify the documents that you discussed with Counsel for this deposition that haven't been that haven't been marked as exhibits this morning or this afternoon?
A. Yes.
MR. HUTTON: Let me object to the question, based upon breach of the understanding of the agreement you have with Pennsylvania counsel in this case.
MR. FOWLER: I keep on telling you we don't have that agreement.
BY MR. FOWLER:
Q. So would you identify those documents for me, then, sir?
A. Yes. We reviewed a copy of Dr. Petty's deposition.
Q. When did you first see Dr. Petty's deposition?
A. Sometime last week, I believe.
Q. Were any particular sections of that deposition highlighted or pointed out for you by Counsel?
A. It was my copy. I didn't make any marks on it, as I recall, but we did talk about it in a general way.
Q. And what general things did you discuss about the deposition?
A. Just what he said: Issues relative to screening.
Q. Anything in particular?
A. General issues about the validity of screening.
Q. Identify some of those issues for me.
A. Whether it's good or bad, what are the best ways to do it: The kinds of things that we would put in our report.
Q. Did you discuss any of the down sides of particular testimony that was given by Dr. Petty?

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A. Down sides?
Q. Any problems with the testimony from Plaintiffs' point of view.
A. Not that I recall.
Q. Did you talk about whether the use of the word "problematic" -- or, I'm sorry, the use of the word "threshold" on page 5 was problematic in any way?
A. I don't believe we did.
Q. Did you come up with that conclusion on your own in reviewing the deposition of Dr. Petty?
A. I have already testified that I don't think the word "threshold" was the proper word, that we shouldn't have used it there.
Q. Okay. Have you talked to Dr. Petty since he gave his deposition on the 25th of last month?
A. Yes, I have.
Q. When did you talk to him?
A. I believe it was yesterday.
Q. What did you talk about?
A. We talked about how the deposition went.
Q. Did he tell you what a nice guy I was?
A. He said you were a nice man.
Q. What else did he tell you?
A. He said it took a long time and that you were going to be on the telephone with him even longer.
Q. Did he tell you anything else about the deposition?
A. I think that was the general gist of it. I said I'd already seen a copy of the transcript, and he said fine.
Q. Did he give you any idea as to what topics to expect in the deposition?
A. No. I told him I had seen the deposition, so I had a feel for what the topics would be.
Q. Okay. Have you talked to anybody else about Dr. Petty's deposition other than Counsel and Dr. Petty, himself?
A. I believe that's all.
Q. Now, you've given --
A. Wait.
Q. Okay.
A. You want honesty here. I told my prayer group yesterday that I was going to be deposed by you, and they said they'd pray for me.
Q. Did you tell them to pray for me, too?
A. No, I didn't.
Q. Okay.
A. I didn't tell them I read Dr. Petty's deposition.
Q. Did you talk to Dr. Petty about his testimony in the Broin case at all? B-r-o-i-n case?
A. Is that the flight attendants thing?
Q. Yes, sir.
A. He said to me that he was -- something to the effect that he was very surprised that the people -- that people who were taking his testimony had a copy of his deposition, they had gotten it so quickly, and that he was upset because he hadn't yet signed it as being accurate.
Q. Did he tell you anything else about the Broin testimony?
A. That's all as I recall.
Q. Did he suggest that anything in the

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deposition was inaccurate when he talked to you over the phone?

A. I told him that I had a problem with the word "threshold" as we used it in there, and he said he agreed with that.

Q. But he had an opportunity on the stand in Broin to explain that and he didn't, did he?

A. I don't know.

Q. You've given us, I think, Deposition Exhibit Number 12 that is titled "Thomas M. Hyers, M.D., Depo and Court Testimony" for the years '97, '96, '95 and all the way back through '91. Correct?

A. Correct.

Q. Is that a complete, or as far as you are aware, complete summary of the cases in which you've testified by deposition or in court since 1991?

A. I believe it is, including '91.

Q. Including '91; thank you, and in just quickly looking through, I don't see any cases involving tobacco litigation. Is that accurate?

A. There were no cases where a tobacco company was a defendant; that's correct.

Q. Okay, and you testified in a fair number of asbestos cases; is that correct?

A. That's correct.

Q. And those have been exclusively on behalf of the plaintiffs? Is that correct?

A. That's correct.

Q. Is there a common theme that runs through your testimony in those asbestos cases?

A. It has to do with our screening of a number of workers with asbestos-induced lung disease and my expert testimony as to whether or not they have asbestos-induced lung disease.

Q. Do you ever testify about cigarette smoking in those cases?

A. That subject frequently comes up.

Q. And in what context does that subject come up in those cases?

A. The subject comes up mostly in the context of causation of lung cancer.

Q. Have you ever testified that a particular person's lung disease was not caused by or contributed to by cigarette smoking?

A. That a smoker with lung disease, that it was not caused by cigarette smoking?

Q. Or contributed to, yes. Let me ask that question. That was a horribly vague question. Have you ever testified in any of those asbestos cases that cigarette smoking wasn't responsible, in whole or in part, for the disease suffered by that individual?

A. Yes.

Q. Has that ever been true with regard to a particular type of lung cancer?

A. Are you including mesothelioma?

Q. Yes.

A. In regard to mesothelioma, I do not think cigarettes are implicated.

Q. Now, with regard to any other type of lung cancer, have you ever testified that someone's smoking history didn't cause or contribute to their lung cancer?

A. I don't believe I've been able to say that.

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Q. What percentage of your testimony is given on behalf of the plaintiffs, would you say?
A. In the asbestos litigation?
Q. In all the litigation since 1991.
A. On the form I gave you, you'll see a designation what's plaintiff and what's defense in medical malpractice. The "P" stands for plaintiff, and the --
Q. "D" stands for defense?
A. The "D" stands for defense, and I've tried to split the medical malpractice testimony between the two groups, based upon the merit of the case. It looks like the plaintiff has been a little more frequent than the defense.
Q. Well, if you can take a look at 1995, you've got -- I'll count them -- two, four, six, eight, ten, twelve, fourteen, sixteen, eighteen, twenty cases in which you've testified either by deposition or trial; correct?
A. Correct.
Q. And nineteen of those for the plaintiff, one for the defense; correct?
A. Again, as I said, the medical malpractice, not the product liability, but the medical malpractice, there are three, and one of those was defense and two was for plaintiff.
Q. And for 1995, nineteen for plaintiff and one for defense; correct?
A. Overall, that's correct.
Q. What's your usual fee for your work in litigation, sir?
A. Three hundred dollars an hour for reviews and preparation of reports, four hundred dollars an hour for testimony given at deposition or at trial.
Q. Before I forget it, I'll hand you my card, and if you would just forward the bill directly to me for your time spent during this deposition today, we'll take care of that.
A. Thank you.
MR. KLEIN: Let's go off the record for one sec.
(Discussion off the record.)
BY MR. FOWLER:
Q. And Doctor, we just had a short discussion off the record. As we discussed off the record, it may be that your own counsel will pay you for -- or the Plaintiff's counsel will pay for the time, but if it works out that defense will pay your time during deposition, if you would send me that statement, I'll pay it right away; okay?
A. Thank you.
Q. How did you arrive at the three hundred an hour for review and four hundred an hour for testimony figures?
A. It's a reasonable rate for this kind of work in the Midwest, in my experience.
Q. And so you just gauged it based upon what was done here in the Midwest, given your experience and the nature of the cases that you testify in; is that correct?
A. Well, I've been doing this, now, for about ten years, and that seems to be acceptable to most people, and in limited conversations, that seems to be

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what other people charge. Some people charge more, some less.

Q. What percentage of your income derives from consultation, or review, or testimony as it relates to litigation?

A. In any given year, somewhere between five and ten percent.

Q. Have you made any presentations of any variety regarding tobacco or smoking issues?

A. Scientific presentations?

Q. Yes, sir.

A. I believe I was on a program at the American Thoracic Society some years ago in regard to the benefits and methodology of smoking cessation. I've also -- I've also published the abstracts that you've already seen.

Q. Have you made any presentations of any variety regarding how to design a proper medical monitoring program?

A. I've talked about, presented our -- we have presented our medical monitoring program in asbestos in these abstracts, as well as in informal meetings with other scientists. Those are the only things I can tell you about.

Q. Would those be, those presentations be reflected on your CV?

A. None of the abstracts are on my CV.

Q. What about any presentations that were made concerning the abstract?

A. They are not on there.

Q. Have you -- well, we'll get to that later.

Do you belong to any tobacco control organizations?

A. I'm not sure what a tobacco control organization is.

Q. An organization that has as its primary focus controlling or reducing tobacco use in the United States or throughout the world.

A. As its primary focus? I don't think I can say that I'm a member of any such organization.

Q. How about any -- do you have any memberships to organizations that have as one of their planks, one of their goals, tobacco control?

A. Well, the American Thoracic Society is on record as being very much against cigarette smoking. In that sense, I'm a member of that organization. I don't know whether you can say they have a primary plank that deals with tobacco control.

Q. Are there any other organizations that you belong to that, for instance, the American Lung Association, if you are a member there, or any of those other, American Cancer Society, et cetera, that have an anti-smoking point of view?

A. The American Thoracic Society is the medical arm of the American Lung Association. The American College of Chest Physicians, of which I am a member, has been opposed to cigarette smoking. The American Heart Association -- I've worked closely with them -- has been opposed to cigarette smoking.

Q. And you endorse that same view, do you not?

A. I have spoken publicly about the hazards and dangers of cigarette smoking and tobacco use, yes.

Q. If it were within your power, would you like

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to simply get rid of cigarette smoking in the United States?
MR. HUTTON: Let me object. We're not talking about things that are on Venus or Mars, here. Let's get realistic with our questions.
A. I don't know how I would ever have the power to do that.
BY MR. FOWLER:
Q. If you did, though, would you like to simply get rid of all smoking and tobacco use?
A. I just don't know how to respond to that question. It seems so out of the realm of the possible for an individual to be able to do that. I mean, I don't see how I would could do that.
Q. Would you like to if you could?
A. I'd have to think about that. I don't know. I don't know the answer to that.
Q. You can't tell me yes or no, as you sit here today?
A. I really can't.
Q. Have you ever worked with Mr. Sheller or Mr. Mellon's firms before?
A. Not prior to this activity.
Q. How about with Mr. Hutton's firm? Have you ever worked with his firm before?
A. I don't believe so.
Q. When were you first contacted about participating in this case?
A. I believe it was sometime in late April or early May of this year.
Q. And who were you contacted by?
A. I believe initially by Dr. Petty.
Q. And what did he ask you to do?
A. He asked me to help him prepare a report which eventually resulted in the document which I've already given you.
Q. We'll talk about the preparation of that later. Did he ask you to do anything else?
A. He asked me to either have the lawyers in Philadelphia call me or for me to talk to them. I can't recall which way that went, but he indicated to me that he had agreed to work with them.
Q. And so eventually, lawyers got into contact with you or vice versa from Philadelphia? Is that correct?
A. That's correct.
Q. And who was your first contact?
A. It was either Mr. Mellon, Mr. Thomas Mellon, or someone in his office.
Q. And when would that contact have taken place?
A. Again, sometime in late April or early May.
Q. Did you make any notes of that conversation, by any chance?
A. No.
Q. Did you make any notes of any conversations you've had with any plaintiff's counsel, other experts, other consultants, and so forth in the case?
A. In regard to this matter?
Q. Yes, sir.
A. No, I did not.
Q. Let me ask you, have you worked with any lawyers in Philadelphia before on any matters?

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A. On any matters?
Q. Yes, sir.
A. I don't think so.
Q. Did the report that you prepared in this case go through a number of drafts?
A. Yes.
Q. Do you have any prior drafts?
A. There may be some on the word processor, but I don't believe there would be. I have no written prior drafts.
Q. Have you made any notes or anything else concerning your review of materials in this case?
A. No.
Q. Have you received anything from Plaintiffs' counsel, deposition transcripts, medical records, anything that we haven't marked as exhibits here, today?
A. Yes.
MR. HUTTON: Let me object, based upon the formal agreement.
MR. FOWLER: Alleged agreement.
Let's take a couple-of-minute break, if you don't mind, maybe take five minutes or so. Oh, and by the way -- let's stay on the record for just one second -- Doctor, I should have said this early on, if I didn't: Any time you want to take a break for whatever reason, just let me know and we'll take a break as soon as possible thereafter. Okay?
THE WITNESS: Thank you.
MR. FOWLER: Sure.
(Recess.)
THE COURT REPORTER: (Reading back)
"Q: Have you received anything from Plaintiffs' counsel, deposition transcripts, medical records, anything that we haven't marked as exhibits here, today?
"A: Yes."
BY MR. FOWLER:
Q. And Doctor, what materials have you received from Plaintiffs' counsel that we haven't marked as exhibits here today?
MR. HUTTON: Let me object again, today, based upon the agreement that you have with Mr. Sheller and others.
MR. FOWLER: The near agreement. The unconsummated agreement.
A. I can't tell you precisely. I've already testified that I received a copy of Dr. Petty's deposition transcript and several other documents that were specifically labeled something to the degree of attorney-client work product or work privilege, something like that, and I was told in writing on these not to share them with anyone.
Q. Did you review or in any way rely upon those materials you reviewed for your expert report or your opinions in this case?
A. No.
Q. Can you tell me what materials those would have been, the ones that were marked attorney work product or whatever they might have been marked?
MR. HUTTON: I object.
MR. FOWLER: He can identify them.
A. I, frankly, haven't had an opportunity to

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even look at them enough to tell you what's inside.
BY MR. FOWLER:
Q. Have you reviewed them at all?
A. I've looked at the top sheet that said don't share them with anybody; that's about all I've seen of those.
Q. Have you reviewed any deposition transcripts of the plaintiffs in this case?
A. Of the plaintiffs? The individuals, themselves?
Q. Yes, sir.
A. No, I don't believe I have.
Q. Have you reviewed any of the medical records of any of the plaintiffs in this case?
A. No. Well, let me add one more thing. I got -- I don't know whether they were affidavits or just statements, but they were three defense expert statements or affidavits that I was furnished.
Q. So you did receive three expert statements from defense experts?
A. I did.
Q. What experts were those?
MR. HUTTON: We would object.
A. I haven't looked at them, so I can't -- I'm not even sure I can recall their names. I'm sorry.
BY MR. FOWLER:
Q. You haven't reviewed those reports?
A. Just to look at the front sheet to see what they were. I haven't looked through them.
Q. Did you recognize the names even though you might not recall them here as you sit here today?
A. The names did not strike me as anyone that I knew.
Q. Does the name Dr. Marie Savard ring a bell?
A. I believe that was one of the names.
Q. But you don't recall her from --
A. I don't recall I don't know her.
Q. How about Dr. Abrecht? Does that name ring a bell?
A. I think so.
Q. Was that one of the expert reports that you received?
A. I believe it was.
Q. Okay. What about Dr. Polefsky? Does that name ring a bell?
A. I'm not sure about that one.
Q. Now, do you intend to review these expert reports prior to testifying at trial?
A. If this goes to that point, yes, I will.
Q. Do you intend to review the depositions of the individual plaintiffs prior to trial?
A. If they're furnished to me, I will review them.
Q. But you don't currently have those; correct?
A. I do not.
Q. Do you intend to review the medical records of the plaintiffs before trial?
A. If they're furnished to me, I will review them.
Q. But you don't have them now?
A. I do not.
Q. Have you received any summaries or other information relating to you the smoking history or

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other characteristics of any of the plaintiffs?
A. Not that I can recall.
Q. You haven't examined any of the plaintiffs in this case, have you?
A. I have not.
Q. Do you know how many plaintiffs there are that are named in the case?
A. I do not know.
Q. Do you know the names of any of them?
A. I've heard Arch, and I think I heard Barnes today. Those are the only two names that I believe I've heard.
Q. Have you ever heard the name McNally?
A. No.
Q. How about --
A. Not in that context.
Q. Of course. In connection with this case, you've never heard the name McNally?
A. No, I don't believe I have.
Q. In connection with this case, you've never heard the name Catherine Potts?
A. No.
Q. In connection with this case, you've never heard the name Norma Rodweller?
A. No.
Q. In connection with this case, you've never heard the name Barbara Salzman?
A. No.
Q. That's S-a-l-z-m-a-n.
Same question: In connection with this case have you ever heard the name Edward Slivak?
A. No, I don't believe I have.
Q. When you -- oh, let me ask this question, to make sure I understand. You have not yet reviewed the affidavits of the defense expert witnesses; correct?
A. Of those three, the three that I have, I don't know how many defense expert witnesses there are, but I received three.
Q. Have you received reports or affidavits from any of the other plaintiffs' expert witnesses?
A. I think I have something from a Dr. Burns in there.
Q. Have you reviewed the Burns report?
A. No.
Q. So you have no basis upon which to either agree or disagree with the statements he makes in his expert reports; correct?
A. I'm really not able, at this point, to comment on that.
Q. Have you seen the Burns deposition in this case?
A. No.
Q. Have you seen any Burns depositions in this -- in any case? I'm sorry.
A. I know of Dr. Burns. I don't recall ever reading a deposition by him.
Q. Have you had any conversations with Dr. Burns concerning this case?
A. No.
MR. FOWLER: Off the record.
(Discussion off the record.)
BY MR. FOWLER:
Q. Doctor, are there any other materials that

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you've received from Plaintiffs' counsel that we haven't discussed?
A. I believe that's all.
Q. You haven't received any pleadings, or materials of any variety related to the lawsuit other than what we've talked about?
A. Pleadings?
Q. Oh: The Complaint in this case, where the Plaintiffs outline their allegations, or a defense answer, the answers to interrogatories, or anything like that.
A. I don't believe I have.
Q. So have we now identified everything that you've reviewed in connection with this case?
A. Everything I've reviewed is basically out here. The only other thing is Dr. Petty's deposition testimony.
Q. And you said you didn't mark that?
A. Didn't mark it?
Q. Didn't put underlining or other marks on that?
A. No.
Q. Can you describe to me in your own words what your understanding of this case is? What's the case all about?
A. As I --
MR. HUTTON: Let me object. That's not a fair question for an expert, to give closing arguments as to the case, but go ahead.
MR. FOWLER: I didn't ask him for a closing argument, but go ahead, Doctor; if you can, just tell me what the -- your understanding of the nature of the case is, please.
A. I am not very clear on the nature of the case. As I understand it, this is -- I'll tell you what I was asked to do. I was asked to help prepare a screening methodology to prevent or decrease the likelihood of individuals in the State of Pennsylvania who are at high risk for lung cancer from developing lung cancer.
BY MR. FOWLER:
Q. Is it your understanding that lung cancer was the end point that you were interested in?
A. Well, we were looking at a number of health issues. The issues that we focussed on initially were mostly lung disease, lung cancer, and emphysema or COPD. This was eventually, as we talked about this, we became, Dr. Petty and I became involved in discussions about cardiovascular disease, as well.
Q. Did you and Dr. Petty, during your discussions, come upon cardiovascular disease, or was that directed to you by someone else?
A. Well, a surgeon, Dr. Carolyn Dresler, from Philadelphia from the Philadelphia area has been involved in this, as well, and she helped to focus on both the lung diseases and the cardiovascular diseases. We were also asked for our input in that.
Q. By the way, do you rely upon anything that -- any information you received from Dr. Sklaroff for your opinions in this case?
A. Dr. Sklaroff, as I said, sent me the information I've shown you, and I did look at it and take it into consideration.

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Q. The same question with regard to Carolyn Dresler: Do you rely upon any information that she gave you in arriving at your opinions in this case?
A. I don't recall getting any written information from her. We did have conference telephone calls in which I listened to her opinions and considered them.
Q. And you considered those in connection with your opinions in this case?
A. Pardon me?
Q. You considered those in connection with forming your opinions in this case?
A. I would certainly consider them, yes.
Q. Okay, what about Steven Gam-BEEZ-ee-uh (PHonetic or Gam-BEESH-uh (Phonetic)? I'm not sure how you pronounce his name. It's G-a-m-b-e-s-c-i-a. Have you had any contact or discussion at all with him concerning this case?
A. He may have been involved in some of the conference calls, but I can't really comment that he's -- that I have considered him in preparing our report.
Q. I think there's a Lawrence Frame there, as well; is that correct?
A. That's correct.
Q. Do you recall having any discussions with him, over the phone or otherwise, concerning this case?
A. I remember that he was in on at least one or two of the conference calls.
Q. And did you consider the information that he related in connection with arriving at your opinions in this case?
A. My memory is that he was involved more in the costing, cost analysis, and I've already testified that I am not up to speed on that.
MR. FOWLER: Off the record.
(Discussion off the record.)
BY MR. FOWLER:
Q. Do you know what medical care any of the plaintiffs in this case have received, say, over the past five years?
A. I've seen no medical records of these individuals.
Q. You don't have any information upon which to base an opinion as to whether Plaintiffs are currently, through their own doctors, receiving adequate medical care, are you?
A. I can't address that question. I don't know.
Q. And you don't know whether they're getting already, in connection with their medical care, the sort of monitoring that might be appropriate for them; correct?
A. I don't know.
Q. Let's talk about the conference calls that you've had a number of times with, I think, lawyers and other persons in connection with this case. You said you've had three to five? Is that correct?
A. I believe that's correct.
MR. HUTTON: I object to any questions regarding conference calls with counsel, based upon the prior understanding you have with Mr. Sheller and the

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Pennsylvania lawyers.
MR. FOWLER: Alleged understanding.
BY MR. FOWLER:
Q. Were counsel always involved in those conference calls?
A. Counsel? You mean Mr. Mellon's group?
Q. Some lawyer of some variety for the Plaintiffs.
A. I believe an attorney was always involved with those calls, yes.
MR. KLEIN: And there's a lot of variety among the attorneys.
MR. HUTTON: Greg, when the table is turned and we're inquiring of your experts conversations you've had or your people have had with your experts, is that fair game to discovery?
MR. FOWLER: You know, whatever the rules dictate.
MR. HUTTON: That's a non-answer, "whatever the rules dictate." I'm just trying to pin you down.
MR. FOWLER: I went to law school to learn how to answer questions like that.
BY MR. FOWLER:
Q. The three to five conference calls, Doctor, that you had, did those always involve issues concerning medical monitoring?
A. Yes.
Q. And were those conference calls -- what was the purpose of those conference calls?
A. To exchange information.
Q. So who would have been involved in those calls?
A. Dr. Petty, myself, some of the attorneys, Dr. Dresler, Dr. Sklaroff. Dr. Frame, I believe, was involved in one or two of them.
Q. Was Dr. Gambescia involved in any of those?
A. He may have been, and I don't recall.
Q. What about Dr. Burns?
A. I don't recall that he was involved.
Q. And what format did those calls take?
A. Format of a conference call, where we would discuss drafts of the report that we were preparing. It was important, I think, from the point of view of the attorneys, to settle on the -- to reach some consensus about the type of medical monitoring that we would recommend, so that a cost analysis could be performed.
MR. HUTTON: Let me object to the last question. The witness is very quick, and sometimes doesn't allow me to make a timely objection.
You are doing well.
THE WITNESS: You want me to talk slower?
MR. HUTTON: You are doing well. No, I just need to try to see if I can beat you to the punch, here, before you answer. You are doing very well.
BY MR. FOWLER:
Q. And so one of the purposes of the call, then, was to reach some consensus as to what medical monitoring program would be suggested by this group of expert witnesses in conjunction with the lawyers; correct?
A. To settle on a final monitoring program, a final recommendation, yes.

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Q. Here's the page I was looking for. Doctor, do you have any knowledge --

MR. HUTTON: Let me object to that prefatory statement. Go ahead.

MR. FOWLER: Did you get a preparatory (sic) statement on the record? You can go ahead and take that off the record, if you'd like to.

BY MR. FOWLER:

Q. Let me start the question again. Doctor, do you have any knowledge regarding what monitoring Plaintiffs are currently receiving?

A. No.

Q. And Doctor, in connection with the phrase "medical monitoring" or with the phrase "medical screening," am I correct in understanding that that phraseology refers to medical examinations of asymptomatic persons?

A. That is what the term has been used. I would just add for the record that most smokers are not asymptomatic. They nearly all cough.

Q. But Doctor, medical monitoring and/or medical screening -- well, let me just ask this question. Medical monitor, medical screening, those are synonymous phrases, are they not?

A. You're using them synonymously.

Q. May I appropriately use them synonymously?

A. In this context, I think I understand what you mean.

Q. And so may I, with your permission, use those interchangeably?

A. In this context, yes.

Q. In what context could I not use them interchangeably?

A. Well, I think the issue has to do with whether we're talking about monitoring a large group of people or whether we're talking about the kind of medical monitoring that a private physician does with an individual patient. There are different kinds of medical monitoring. You've talked about medical monitoring of individual plaintiffs here. We tried to prepare a report that would be a doable, feasible kind of medical monitoring for a larger population of people.

MR. FOWLER: Could you read that answer back? I'm not sure I understood that.

MR. HUTTON: Let me object to that last comment. You can have it read back, but you shouldn't disparage the answer. I think it was brilliant.

MR. FOWLER: And maybe that's why I didn't understand it. I wasn't necessarily disparaging the answer. It could have been the recipient of the answer, and I'll acknowledge that freely.

So if you could read that back. Read the question too, please.

THE COURT REPORTER: (Reading back)

"Q: In what context could I not use them interchangeably?

"A: Well, I think the issue has to do with whether we're talking about monitoring a large group of people or whether we're talking about the kind of medical monitoring that a private physician does with an individual patient. There are different kinds of medical monitoring. You've talked about medical

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monitoring of individual plaintiffs here. We tried to prepare a report that would be a doable, feasible kind of medical monitoring for a larger population of people."
BY MR. FOWLER:
Q. Doctor, maybe this will help out. Can you tell me what the difference between medical monitoring and medical treatment is?
A. Medical monitoring has more to do with the detection of abnormality. Treatment has more to do with its care and cure.
Q. So once an abnormality is detected, does that then signal the beginning of the treatment phase?
A. It can. It doesn't necessarily follow that you would treat every abnormality that you detect.
Q. But for any medically significant abnormality, you would treat it if you had treatment available, wouldn't you?
A. Not necessarily. Again, it's a judgment that's made by a physician and a patient together.
Q. Because once you have an abnormality, you would still need to make an individual assessment as to whether treatment made sense for that individual, would you not?
A. That's correct.
Q. Would you agree with this definition of screening? "Screening is the application of a test to detect a potential disease or condition in a person who has no known signs off symptoms of that disease or condition"?
A. That's one definition.
Q. Is that one that you would agree with?
A. Well, it's a very broad definition. For instance, we only continue our monitoring program in our asbestos individuals, our asbestos-exposed individuals, in those who have already been shown to have x-ray abnormalities. We don't do -- so in that sense, they're not normal. They have signs. We don't do continued monitoring in people, even though they may have a history of asbestos exposure, without some chest x-ray abnormality, but in general, the definition that you read for screening, I think, is acceptable.
Q. And I read, and I'm not trying to make an exhibit of this, but what I was reading from, just for your information, was "Common Screening Tests" by David M. Eddy. Do you see that?
A. I see that.
Q. Do you recognize David Eddie as an authority or expert in the field of monitoring?
MR. HUTTON: Objection to the use of the word "expert": Vague.
A. I did not know of Dr. Eddy until I saw his name mentioned in Dr. Petty's transcript.
Q. So you don't know whether he's an expert or not in the area of medical monitoring?
A. I don't know him.
Q. Can you name for me any authors that you consider authoritative in the general area of medical monitoring?
A. Any individual --
Q. Yes, sir.
A. -- authors?
Q. Yes, sir.

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A. I'm not sure I can name an individual off the top of my head. There are a number of agencies and institutions that make monitoring recommendations, these are usually made by committees. If you want to know one name in this area that I consider an authority, it would have to be Dr. Petty.

Q. Can you name me a single other authority in the area of medical monitoring?

A. In general?

Q. Correct.

A. I consider myself an authority in the area of medical monitoring of people with asbestos exposure.

Q. Can you name me any other authorities in the area of medical monitoring generally?

A. I think Dr. Burns is probably an authority, from my, my knowledge of his, his work.

Q. What about his work makes you believe that he's an authority in the area of medical monitoring?

A. He's been involved in cigarette smoking-induced disease, tobacco-induced disease for a number of years, and has been involved in community efforts at control.

Q. Has Dr. Burns ever designed a medical monitoring program that had been implemented?

A. I don't know.

Q. Wouldn't the design and implementation of a medical monitoring program be some indicia of expertise in the field?

A. It would be one indicator, yes.

Q. What other indicators would there be?

A. People who have published review articles, people who have been recognized by their peers, people who have been involved in community health: Not necessarily in designing and implementing, but in the conduct of such study.

Q. Doctor, with regard to your monitoring and treatment of patients with asbestos-related conditions, do you routinely monitor persons who are asymptomatic for asbestos-related conditions?

A. As I testified earlier, the people who we follow are the ones who have abnormalities on their chest x-ray. If we find individuals with a history of exposure who have no chest x-ray abnormality or no disease that's thought to be linked to asbestos, we don't routinely follow them or monitor them.

Q. Without regard to their level of exposure?

A. Pardon me?

Q. Without regard to their level of exposure?

A. In general, that's correct. They have to have chest x-ray abnormality or some other evidence of disease.

Q. So if they're asymptomatic, you don't routinely monitor them; correct?

A. Let me just be sure the terminology is correct, here. Symptoms refer to what you feel or what you experience. Findings refer to more objective things that you detect in physical exam or chest x-ray, so what I'm talking about are findings. The great majority of the individuals that I have are symptomatic, in my screening and monitoring program, but my decision to continue to monitor them is based on the finding, not on the symptomatology.

Q. Okay, so if they're asymptomatic and have no

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abnormal findings, then you would not routinely monitor those people; correct?

A. That's correct, --

Q. Got you.

A. -- in my program. Now I'd still -- let me just adjust a little bit of clarification, there. I'd still make every effort during the initial screening examination to influence their health practices, such as smoking, but I wouldn't follow them in a longitudinal-type study.

MR. FOWLER: I'd move to strike the last portion of that answer as nonresponsive.

MR. HUTTON: I move it be reinstated. It's quite responsive.

MR. FOWLER: Would you read back the last statement of Counsel, please?

THE COURT REPORTER: (Reading back)

"I move it be reinstated. It's quite responsive."

MR. FOWLER: That could get pretty circular quickly, so I don't think I'll object to that objection.

BY MR. FOWLER:

Q. Do you hold yourself out to your patients or colleagues as an expert in psychiatry?

A. No.

Q. Do you hold yourself out to your patients or colleagues as an expert in issues relating to addictions of any variety?

A. I'm most experienced in the addiction to nicotine, but I am not an expert in the area of addictive medicine.

Q. So I'm not sure if I understand. Do you hold yourself out to your patients or your colleagues as an addiction expert?

A. No.

Q. Okay, do you treat addiction of any variety as a specialty practice?

A. I deal with addiction to nicotine every day. I treat that every day, but that is the only addiction that I'm frequently involved with as a therapist.

Q. In what context do you treat it?

A. I treat it in the context of trying to get people to stop smoking and using tobacco products.

Q. You tell them to quit; correct?

A. That's one thing I do.

Q. What else do you do?

A. In the past, I've prescribed various nicotine replacements. Those now can be obtained over the counter. I've referred people to behavioral medicine interventions. I have mobilized their spouses as aides. I've done a number of things in an effort to get people to stop smoking.

Q. Do people ever stop smoking when you tell them to and with no other pharmacological or other assistance?

A. They do.

Q. You are not a member of the American Society of Addiction Medicine, are you?

A. I am not.

Q. Have you made a thorough study of the literature with regard to addiction of any variety?

A. I am not an expert in addiction, and my only

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experience is with addiction to nicotine. I am not -- I have not studied all of the literature on nicotine addiction.

Q. Have you published any articles about what you believe to be nicotine addiction?

A. Published any articles about nicotine addiction?

Q. Correct.

A. No.

Q. Have you published any articles concerning the efficacy of gum, or nicotine gum, or nicotine patches with regard to smoking cessation?

A. No.

Q. Have you published any articles at all regarding any aspect of nicotine addiction, smoking cessation, or anything of that variety?

A. Our abstract is the article that is not a peer-reviewed article but is the information about smoking cessation publications that I've already furnished you.

Q. Do you hold yourself out to your patients and colleagues as an expert in pharmacology?

A. No.

Q. What about psychopharmacology?

A. Psychopharmacology?

Q. Correct.

A. No.

Q. Do you hold yourself out to your patients and colleagues as an expert in behavioral psychology?

A. No.

Q. Same question for consumer behavior.

A. Consumer behavior?

Q. Correct.

A. No.

Q. Do you hold yourself out to patients and colleagues as an expert in epidemiology?

A. No.

Q. Same question for statistics.

A. No.

Q. Do you hold yourself out to your patients and colleague as an expert in cost/benefit or risk/benefit analysis?

A. No.

Q. You don't hold a Master of Public Health degree, do you?

A. I do not.

Q. What exactly is a Master of Public Health degree, if you know, sir?

A. What exactly is it?

Q. Yes, sir.

A. It's a graduate degree in the field of public health.

Q. Do you know what its focus is?

A. It depends on the curriculum that the individual pursues, but in general, it includes some training in epidemiology and biostatistics as it relates to public health issues.

Q. Are you an expert in medical ethics?

A. I'm published in medical ethics. I consider myself to be knowledgeable.

Q. What publications have you prepared on medical ethics?

A. I'd have to get my CV to show you.

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Q. I hand you what's been marked as Exhibit Number 2. You can work off the actual exhibit.

(Witness peruses said document.)

A. I would refer you the to page 5, I believe, "Community and National Responsibility," item number 1, 2, 3, 4 -- item number 4, "Chairman, NIH Workshop on ethical Decision Making in Ventilator Therapy, Washington, D.C., 1985," that resulted in a publication of which I was the principal author, number 41 on my CV, entitled "NIH Workshop Summary. Withholding and withdrawing mechanical ventilation."

Q. Doctor, would you agree that there are distinct ethical issues raised by any plan that would seek to monitor asymptomatic individuals for disease?

A. I believe there are ethical issues, yes.

Q. And you would agree that there -- or do you know whether there's literature that's been published with regard to those ethical issues?

A. I can't quote it, but I'm sure there has been such literature.

Q. Have you read any of it?

A. I can't quote it off the top of my head.

Q. My question is have you read any of it.

A. I don't recall.

Q. What are the ethical issues that you feel are raised by a program that would seek to medically monitor asymptomatic persons for potential disease?

A. I think the issues revolve around the possibility of doing harm to someone who's asymptomatic. For the record, I would again say that most smokers are not asymptomatic; they cough nearly every day. There's also issues relative to the cost, which has become a topic of ethics these days, of any monitoring program, versus the benefit that it might result in.

Q. You've mentioned cough a couple of times. Do you think it's appropriate to medically monitor smokers based upon coughing as a symptom?

A. Not cough alone.

Q. Would you agree that with regard to medical monitoring of asymptomatic persons, that false positives raise issues that need to be considered?

A. False positives have to be considered.

Q. What false positives are possible in a medical monitoring program such as the one that you suggest?

A. The chest x-ray could show an abnormality that might be interpreted as cancer and would not be. The spirometry might be abnormal based on the effort, a lack of effort of the patient or the subject, rather than some sort of intrinsic lung disease. The cytology could be misinterpreted as positive when it is not.

Q. If cytology was misinterpreted as positive when it was actually negative, and if chest x-rays showed a spot that wasn't cancer, that would lead to additional diagnostic testing, would it not?

A. It could.

Q. And what diagnostic testing may be necessary?

A. It could lead to further imaging studies such as a CT scan, it could lead to bronchoscopy.

Q. Anything else?

A. It could potentially lead to a surgery.

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Q. Now, do bronchoscopy and surgery pose certain risks to individuals?
A. The risk with bronchoscopy is extremely low, but there is a certain risk associated with it.
Q. How about with surgery? Does surgery pose risk to individuals?
A. There is risk associated with any sort of surgery.
Q. And so those would be risks associated with the false positives in a medical monitoring program such as the one that you would -- that you would propose in this case?
A. They are potential risks.
Q. Okay. Now, if someone is the subject of a false positive and they're told that they may have a cancer of the lung, would that result in anxiety?
A. It could.
Q. And would anxiety be a down side or a possible risk associated with a medical monitoring program, as a result of a false positive?
A. In a very broad sense, I guess you could consider anxiety a risk.
Q. Would you consider it a harm?
A. Anxiety a harm?
Q. Yes, anxiety a possible harm.
A. I guess it's possible.
Q. Let's talk about false negatives for a minute. What is a false negative with regard to -- in the context of the medical monitoring program that you suggest?
A. A false negative means that the disease is present but it is misinterpreted as being absent.
Q. And what flow-on effects might that have in a particular patient?
A. What?
Q. Flow-on effects. How might a patient respond to a false negative?
A. I just I missed that word.
Q. How might a patient respond to a false negative?
A. Okay, I missed the word before that. "Flow-on," did you say?
Q. Oh, yeah, flow-on effect.
MR. KLEIN: It's two words.
A. F-l-o-w o-n? Okay, I just never heard that.
MR. FOWLER: Poor use of the English language.
(Discussion off the record.)
BY MR. FOWLER:
Q. What effect might a false negative have on a patient?
A. If a potentially life-threatening disease were missed and it were present, it could be -- it could result in disability or even death.
Q. Now, if a condition is missed, might -- in other words, the patient is the subject of a false negative -- might that diminish the patient's desire or motivation to change a behavior, a modifiable behavior that may improve their health condition?
A. It's a very broad question. Maybe you could rephrase it a little more specifically.
Q. As I understand it, in reading your report, one of the benefits to medical monitoring, as you see

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it, would be to use as an opportunity to suggest to a patient that they ought to cease smoking because you've detected some abnormality. Correct?

A. Correct.

Q. Now, if you have a false negative, in other words, there is a condition present and it's not detected by the screening methodology, isn't it likely or possible that someone who might otherwise quit smoking wouldn't because they have this reassurance, this false reassurance of health?

A. That's possible.

Q. And that if it actually took place, would be a harm or a risk associated with the medical monitoring program; correct?

A. It could be.

Q. Doctor, do you consider yourself an expert or do you hold yourself out as an expert to your colleagues or patients as an expert in the marketing of consumer products?

A. No.

Q. Do you hold yourself out to your colleagues or patients as an expert in cigarette marketing or promotion?

A. No.

Q. Do you hold yourself out as an expert to your patients or your colleagues as an expert in cigarette design or manufacture?

A. No.

Q. You don't contend, do you, that there is any modification to a cigarette that would make it unnecessary for a patient who smoked that cigarette to undergo medical monitoring, as you view it, do you?

A. In the context of the monitoring that we recommended, the answer is I do not have that contention.

MR. FOWLER: Could you do me a favor and read back that question for me?

THE COURT REPORTER: (Reading back)

"Q: You don't contend, do you, that there is any modification to a cigarette that would make it unnecessary for a patient who smoked that cigarette to undergo medical monitoring, as you view it, do you?"

MR. FOWLER: And the answer was?

THE COURT REPORTER: (Reading back)

"A: In the context of the monitoring that we recommended, the answer is I do not have that contention."

MR. FOWLER: Okay, why don't we take about a five-minute break, if we could, so I can go through my notes and figure out where I am.

(Recess.)

BY MR. FOWLER:

Q. Okay, just a couple of things to make sure my memory is good. Did you say that you had received anything in connection with Dr. Burns? In other words, did you receive any expert report or anything that Dr. Burns would have drafted?

A. I think I saw, I have a report of Dr. Burns which I have not read.

Q. Do you know how long ago you received that?

A. I don't know.

Q. But not in the last few days, but some weeks or something like that?

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A. I don't think so. I don't think I received it in the last few days.

Q. Doctor, in your personal practice, have you ever experienced a situation where someone, upon chest x-ray, showed a spot on their lung that was thought to be, perhaps, lung cancer that turned out to be something other than lung cancer?

A. Yes.

Q. In that particular circumstance, or think of one of those circumstances, did the patient, when informed that they may have lung cancer, act with some anxiety, react with some anxiety?

A. I can't recall specifically. It would not surprise me that that information would provoke anxiety in a patient.

Q. There's even literature, is there not, that such a false diagnosis can lead to clinical depression; correct?

A. I don't know.

Q. Have you ever had a situation when someone had a false positive chest x-ray for lung cancer and had a situation where that patient reacted with some degree of depression?

A. I don't recall that happening.

Q. Do you recall what the reaction of the family members was, if you are aware of it, to the false diagnosis of lung cancer?

A. The, the response I remember in this particular patient was one of relief that it didn't, in fact, turn out to be lung cancer when it was found out that it was not.

Q. So a relief from what? The anxiety of having been diagnosed with lung cancer?

A. I didn't diagnose it. I said there's a possibility, here, of lung cancer." When it turned out not to be, I recall that the patient and the family were relieved.

Q. And now to replow a little old ground, but I need to make sure I understand this. Now, with regard to medical monitoring versus treatment, and that's the context of this question, if a particular smoker has been diagnosed with a particular smoking-related disease in that individual, there's no need for medical monitoring; is that correct? Because under such circumstances, they would already have been diagnosed with the smoking-related condition; correct?

A. I don't think that's -- again, it's a very broad statement, question, and I don't think it's generally a correct one, and let me just give you a couple of examples. If an individual has mild airways obstruction, in general I, and I think most physicians would follow that individual and monitor that individual, one, to try to get the individual to stop smoking, and two, to see if the airways obstruction progresses or gets better.

Q. But with that particular individual you gave advised to quit smoking and whatever else you would do in order to help them quit smoking would be a form of treatment; correct?

A. It would be, yes.

Q. And once treatment occurs, you are no longer monitoring, are you?

A. I would monitor that individual to see what

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the results of my treatment was, if that individual's airways obstruction progressed or got better.

Q. Have you ever designed a medical monitoring program that would encompass a group of people like that suggested in this lawsuit? In other words, more than two million people?

A. Prior to this?

Q. Correct.

A. I haven't designed a program to monitor more than two million people, no.

Q. Have you, before coming up with the proposal in your expert report, have you ever, before that, designed and implemented a broad-scale or a wide medical monitoring program?

A. Only the medical monitoring program in the asbestos-exposed individuals.

Q. And that was the program that was reflected in one of the abstracts we marked earlier; correct?

A. In both of the abstracts, yes.

Q. Okay. Have you ever conducted a medical monitoring program in a clinical trial in order to determine whether it was efficacious?

A. Have I done it myself?

Q. Correct.

A. No, I have not.

Q. Have you participated --

A. Other than this study that we've already, I've already testified to.

Q. And that's the asbestos study you are talking about?

A. The asbestos study, yes.

Q. Tell me about -- is that a study that's currently ongoing?

A. It is.

Q. And what's the status of that, sir?

A. There are about 3,000 individuals who have been followed for a period of up to ten years. The purposes are to determine the progression of disease in these individuals and the factors that might influence that progression: In addition, to determine interventions that might decrease the smoking rate in these individuals.

Q. And what's the purpose for doing a clinical trial on a medical monitoring program? What do you hope to gain by doing a clinical trial on that?

A. I'm not sure I understand what you mean by "clinical trial." Are you referring to a randomized study where you have two groups?

Q. Correct.

A. In a medical monitoring program?

Q. Yes.

A. In general, I believe the purpose would be to determine if one approach is better than another.

Q. And so when you do a clinical trial of a medical monitoring program, what you are trying to do is establish the efficacy of that program, if any; correct?

A. That's -- again, this is, a bit of this is semantics, but in general -- and I've been involved in a number of these, but only a few clinical studies -- a clinical trial refers to a therapy. A clinical study or a randomized clinical study could refer to an evaluation of a diagnostic technique or an evaluation

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of a screening method, so I would prefer to refer to what we are proposing here as a clinical screening methodology. In general, when that methodology is evaluated or has been evaluated in the past, a randomized clinical study has been said to be the best way to do it, although, in fact, it's rarely done.

Q. But with regard to lung cancer screening by chest x-ray and sputum cytology, randomized clinical trials have been done in the past on those, have they not?

A. Randomized clinical studies, yes.

Q. And why do you say studies, rather than trials?

A. Because in general, trial refers to a evaluation of a therapy. This is not -- these studies that were done in the past were not evaluations of a therapy for lung cancer; they were evaluations of a methodology to detect early lung cancer, so there's a slight difference, there.

Q. I see. I believe I see what you are saying. So you are saying that the subject of study in those NCI studies that were done on sputum cytology and chest x-ray were to evaluate whether chest x-ray sputum cytology were appropriate techniques, rather than the treatment that was used for the smokers that were subjects of the study; correct?

A. In general, that's correct.

Q. Okay, is there anything you can tell me that would help me understand that distinction more carefully or more fully?

A. In general, the medical literature refers, when they use the term "clinical trials," they are talking about an evaluation of a treatment. A clinical trial is an evaluation of a treatment, so it might be one drug versus another, or surgery versus a drug, or surgery versus radiation therapy, but it's all about treatment.

A clinical study can be an evaluation of a screening method or a diagnostic approach, and it, too, can be randomized. That is, you can have two arms, and the approach to the evaluation or the screen, or the diagnosis is randomly allocated. In general, that is, in my opinion, the proper way to refer to those two things, to keep them separate. Otherwise, you get diagnosis mixed in with therapy, and it gets a little confusing.

Q. Have you ever published an article in a peer-reviewed journal concerning medical monitoring in any fashion?

A. The article that we published -- and again, this is a kind of medical monitoring; it's not longitudinal medical monitoring but it is a randomized clinical study of a diagnostic method -- let me get you the reference -- is number 62, and this is one of those studies where there's so many authors that the -- they aren't listed by name but I was one of the authors. It's called "The PIOPED Investigators. The value of ventilation/perfusion scan in acute pulmonary embolism," so this is a diagnostic evaluation, not a treatment. It's a randomized clinical study.

Q. And that was to demonstrate whether that methodology was valuable in diagnosing acute pulmonary embolism?

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A. That's correct.
Q. And what was your role in that study?
A. I was a member of the Data Safety and Monitoring Committee. My job was to be sure that the study was done properly and safely.
Q. Did you develop the protocol for the study?
A. I helped develop it.
Q. What sort of population of individuals was involved?
A. Hospitalized patients who were suspected of having pulmonary embolism.
Q. And what number of individuals were studied?
A. Over a thousand.
Q. I asked you earlier if you could identify authorities, individuals who were authoritative in the field of general medical monitoring. Now, I'd like to change that question a little bit and ask if you can refer me to any textbooks or other sources of information that you would consider authoritative in the area of medical monitoring generally.
A. Of medical monitoring?
Q. Correct, or medical screening tests.
A. I believe -- I don't know that I would consider him an authority, because I've already testified that I don't know him, but his -- Dr. Eddy has published a book which I have not seen.
The government has published, put out some guidelines.
The American College of Physicians has, a number of different professional groups have put out guidelines or recommendations for what we should be monitoring for and what we should not.
Q. Does the American Cancer Society put out such guidelines, as well?
A. They occasionally do.
Q. Does the American Cancer Society recommend any types of medical screening at all, medical monitoring at all for any disease end point?
A. I believe they do.
Q. And what disease end points would they be?
A. I believe they have some recommendations in regard to mammography and pap smears. I believe they have some recommendations in regard to testing bowel movements for occult blood or hidden blood, and I believe they have a number of recommendations for monitoring for early cancer.
Q. Do they have any recommendations concerning the monitoring of asymptomatic smokers?
A. For cancer?
Q. For lung cancer or any other disease.
A. I don't know what their current recommendations are. I believe as late as 1993, they were not recommending routine monitoring.
Q. In asymptomatic smokers?
A. Correct.
Q. For any disease end point?
A. For lung cancer, I can say I don't think they were.
Q. You said that some governmental entity had published recommendations concerning medical monitoring or screening. Do you know what entity that was?
A. It used to be called the Public Health Service. Now it's a part of the Department of Health

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and Human Services, I believe it's called.
Q. And do you know what the name of their publication is?
A. There are a number. I can't quote them. I believe you referred to at least one of them in the deposition you took from Dr. Petty.
Q. Were you familiar with that publication that I referred to in Dr. Petty's deposition?
A. I haven't seen it recently. I have seen it.
Q. Are you familiar with the Guide to Clinical Preventative Services published by the United States Preventative Services Task Force?
A. I believe that's the document you referred to.
Q. Right. Had you heard of that before you read it in Dr. Petty's deposition?
A. I believe I had.
Q. Had you ever reviewed a copy of it?
A. Not in total. I've seen parts of it. I believe it's gone through several editions, actually.
Q. Have you seen the most recent edition, to your knowledge?
A. I don't think I have.
Q. Okay. When was the most recent edition published?
A. I don't know.
Q. Do you have any reason -- well, do you have any understanding as to whether the Guide to Clinical Preventative Services is authoritative in the field of medical monitoring?
A. Well, it's certainly big and thick, and I can't really comment, not having seen the most recent edition, as to how authoritative I would consider it.
Q. Now, when you go to design a medical monitoring program -- which you've done at least one time, correct?
A. Correct.
Q. What source did you go to to make sure that, that you are considering everything you need to consider in terms of medical monitoring?
A. In the program that we designed, we basically went to information that was published in what we call the peer review literature; that is, original scientific articles that have been peer reviewed, to try to get some information that would help us design this monitoring program.
Q. And in that connection, you reviewed the literature that was marked as Deposition Exhibit Number 4; correct?
A. I'm sorry, I thought you were talking about the asbestos program.
Q. Oh, I'm sorry. No, I was talking about the current one.
A. That was -- yes, that was what I reviewed in regard to the paper that we prepared.
Q. Can you think of any other sources that you consider authoritative in the field of medical monitoring generally?
A. Sources?
Q. Yes.
A. In terms of publications?
Q. Correct. I'm talking about, you know, textbooks or things like the Guide to Clinical

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Preventative Services.
A. Yeah, most of the textbooks of clinical medicine don't have a lot of information in them about medical monitoring, and I can't quote you a source right off the top of my head.
Q. What percentage of your professional time is devoted to medical monitoring programs?
A. Ten to fifteen percent.
Q. And of that ten to fifteen percent of your medical -- of your professional career, quote, "devoted to medical monitoring," what does that ten to fifteen percent entail?
A. It entails seeing individuals who have been asbestos exposed, reviewing their chest x-rays, reviewing their pulmonary function tests, examining them, taking histories, counseling them on health maintenance practices, reviewing data from school hemocult screens, that kind of activity, and then preparing reports and publications.
Q. And that's with regard to asbestos; correct?
A. That's correct.
Q. Okay. Have you ever published on the efficacy of chest x-ray or sputum cytology in terms of early detection of disease?
A. No.
Q. Have you ever published on the issue of using ECG's or EKG's for the early detection of disease?
A. No.
Q. Have you ever published on the efficacy of pulmonary function testing for the early detection of disease?
A. I don't believe so.
Q. Have you ever -- well, let me ask you this question. Is spirometry different from pulmonary function testing?
A. Spirometry is a component of pulmonary function testing.
Q. Could you tell me or describe for me generally what pulmonary function testing is and what portion spirometry is of that?
A. Spirometry involves the measurement of the total amount of air that can be inhaled into the lungs and then the total amount that can be exhaled with a forced rapid expiration. That forced rapid expiration is then broken down into various subcomponents which are measures of the speed at which the air is forced out of the lung.
Q. And what part of that is spirometry? Is that all spirometry?
A. That's all spirometry.
Q. Okay, what additional elements or whatever does pulmonary function testing bring to that?
A. There's an amount of air that's left in your lungs after you force as much out as you can; that has to be measured indirectly. Those are commonly referred to as lung volumes. There is measures of the efficiency of gas exchange; that is, how well you get oxygen into your blood and how well you get carbon dioxide out of your blood and into the air. Those tests are also part of more extensive pulmonary function testing.
Q. And in the program that you suggest in your expert report, you limit that to spirometry; correct?

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A. That's my approach, yes; that's what I'm recommending, and that's what I believe Dr. Petty is recommending.
Q. And you don't recommend full pulmonary function testing, do you?
A. Not as a part of a screening methodology.
Q. Because full pulmonary function testing wouldn't be necessary, in your opinion, for your medical monitoring program?
A. Not routinely.
Q. Do you, in your medical monitoring program proposed for this lawsuit, recommend that an EKG be done?
A. I believe that there is reference to that in the, in the proposal.
Q. Let me just give that to you so I'm not trying to test your memory.
A. Yeah.
Q. Go ahead and take a look, if you don't mind, sir.
(Witness peruses said document.)
A. This doesn't, I don't believe this has the actual --
(Witness continues to peruse said document.)
A. -- menu in it. Excuse me. May I look at this?
BY MR. FOWLER:
Q. Sure. Go ahead, please.
(Witness peruses various exhibits.)
A. In the Exhibit 6, Figure 4, there is a reference to performing an electrocardiogram.
Q. But that's not your expert report, is it?
A. That is not my expert report.
Q. That's something different from your expert report, isn't it?
A. That is correct.
Q. I don't believe there's a reference to --
A. Let me check this again.
(Witness peruses said document.)
A. (Continuing) I don't seem to have the, the algorithms and the figures on my copy of the report, so I'd have to see that to tell you precisely what is in this. There's a piece of this that's missing, it looks like to me.
Q. Okay, and the piece of this that you are talking about is your expert report that's been marked as Deposition Exhibit Number 2, I believe; correct? Number 3.
A. Number 3. That's correct.
Q. And that's the copy that you brought with you to the deposition today; correct?
A. That is correct.
Q. So as you sit here today, do you know whether an EKG is something that you recommend in your medical monitoring program?
A. I can't tell you without seeing the appendices and figures.
Q. Is the cardiovascular risk assessment an element of your medical monitoring program?
A. It is.
Q. How about chest x-rays?
A. Yes.

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Q. Is that an element of your screening program?
A. Yes.
Q. What about an exercise stress test? Do you recommend that for your screening program?
A. I, personally, do not.
Q. And does Dr. Petty?
A. I don't believe he does.
Q. And you don't in your report, do you?
A. We do not mention it.
Q. That would be something that you would consider unnecessary with regard to your medical monitoring program that you suggest; correct?
A. I would not recommend it for routine use.
Q. And we've already talked about pulmonary function testing. You don't recommend that for routine use in your medical monitoring plan, do you?
A. I recommend spirometry but not full pulmonary function tests.
Q. What about sputum cytology? Do you recommend sputum cytology be used in your medical monitoring program?
A. We do in selected individuals.
Q. What selected individuals would those be?
A. I believe they are -- and again, I'm saying that from memory -- I believe they are individuals over age 50 who have at least a 20 pack-year history of smoking.
Q. Okay, and Doctor, would someone who is age 25 and above who has smoked an average of, say, 10 to 15 cigarettes per day for ten years be medically monitored under your program?
A. I believe the cutoff is 20 pack-years for medical monitoring, working from memory.
Q. So someone who is 25 who smoked an average of ten or fifteen cigarettes a day for ten years wouldn't be monitored under your program, would they?
A. Again, I'm speaking from memory. I don't believe that person would.
Q. Please go ahead and refer to Deposition Exhibit Number 3.
A. I've already testified that those appendices are not attached.
Q. But if you look at page 6, I think that covers that aspect of the recommendation.
(Witness peruses said document.)
A. You are talking about the second paragraph?
Q. The portion that is the first paragraph under "A practical approach to monitoring."
A. Correct.
Q. And so you recommend monitoring in people who have a twenty or more pack-year history; correct?
A. That's what we recommend.
Q. Okay, and someone who smoked ten or fifteen cigarettes for ten years wouldn't have a twenty pack-year history, would they?
A. That's correct.
Q. So somebody who is twenty-five, ten to fifteen cigarettes a day, smoked for ten years, wouldn't be monitored under your program; correct?
A. I believe that's right.
Q. Okay, and then let's go to someone who is 40 years of age or above, and let's suppose that person

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has smoked for twenty years but smoked an average of fifteen cigarettes a day. That person would have less than a twenty pack-year history, too, wouldn't they? If they smoked fifteen cigarettes a day for twenty years?

A. This is a test; you are asking me how many cigarettes in a pack.

Q. There's twenty cigarettes in a pack.

A. Okay, thank you.

Q. I'm sorry.

A. Since I don't smoke, it's hard for me to keep up with these things. The hypothetical that you posed, that would be less than twenty pack-years, that's correct.

Q. And so that person was 40 who smoked fifteen cigarettes a day for twenty years, wouldn't be monitored under your program; correct?

A. I believe that's correct.

Q. And so by the same token, if somebody was 50 years of age, let's take 45 years of age, somebody who was 45 years of age who smoked for twenty years fifteen cigarettes a day, again that person wouldn't fall within your medical monitoring program, would they?

A. I think that's correct. I think twenty pack-years is the, is the threshold for monitoring, not the threshold for carcinogenesis.

Q. So they wouldn't fall within your medical monitoring program as suggested in this case; correct?

A. I believe that's correct.

Q. Let's take somebody who is 50 years of age who smoked twenty years, smoked fifteen cigarettes a day, that person would have fewer than twenty pack-year history and wouldn't be monitored under your program; correct?

A. I believe that's correct.

Q. Doctor, what appendices do you believe are missing from your report?

A. There are figures, he refers to Figures 3 and 4, Dr. Petty does, I know, in his draft, which I saw at one time, and some algorithms in Appendix A. Let me just see if we have that.

Q. Yeah, on the copy, there, if I can just interject, I'm sorry, sir, there is an Appendix A and an Appendix B on your report, and those are the only appendices that I'm aware of that are referred to in your report.

A. This does not give the -- I see what you are referring to, but this does not give the breakdown by age and by smoking pack-years as to which particular test we'd recommend in this monitoring study, and I just don't have a copy of that. I'd have to look for it.

Q. Doctor, with regard to what testing methodology would be required with a particular given smoking history, would you defer to Dr. Petty to interpret what was necessary and when?

A. We -- no, we had a, we had a consensus that we, we talked about in some detail for some period of time, and I just don't have it in front of me so I can't, I can't tell you what it is, but I would have to see it to tell you what it is. I'm not going to defer to anybody on this.

Q. When you say that "we had a consensus," who

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was -- who comprised that group that reached the consensus?
A. For the most part, the people involved in these conference calls.
Q. As we discussed earlier.
A. Correct.
Q. Is the consensus that you just referred to reflected to -- reflected in the report that's been marked as Deposition Exhibit Number 3?
A. Is it reflected?
Q. In other words, does your report, your report that you coauthored with Dr. Petty, reflect the consensus that you said was reached?
A. It doesn't refer to this consensus by, by name, I don't believe.
Q. What I mean, is it consistent, is your report consistent with the consensus that was reached?
A. Our report is a little more general, in that it says that we are going to start with heavy smokers with twenty or more pack-years and that we're going to do a number of studies, but what I'm saying to you is that there are -- there is a menu which I don't have in front of me that breaks down the years and breaks down all of whom have twenty packs or more and says what tests we would recommend for that particular group.
Q. Does that group --
A. By age.
Q. I'm sorry, does that document exist?
A. I believe it does.
Q. Doctor, let me show you what's been marked as Deposition Exhibit Number 5. Is that what you are referring to?
A. No.
Q. Could you explain to me what exactly that is, sir?
A. That was an early working document. This is dated May 6th, '97. It was sort of a beginning kind of document that led to the evolution of a more advanced document.
Q. Who drafted that document?
A. It's from Bob LaRocca. I don't know who drafted it.
Q. Do you now where -- that's a two-page document, is it not?
A. It is.
Q. And who -- what is the source of the information contained in the second page?
A. The source?
Q. Yes.
A. It came from Mr. LaRocca. I don't know, other than that, where the source was. You'd have to ask him.
Q. But you didn't give that information to him, and I'm just trying to make sure that you didn't give that information to him and he just wrote it down and sent it back to you.
A. I did not give him that information.
Q. And you don't know who did?
A. We talked about this, again, in general, and I can really make your -- I can short-circuit a lot of these questions, and I'm sure I can produce this document for you, but it led to the evolution of a menu of tests, based on age and pack-years, that we would

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recommend. As I recall, the letters of the testing went somewhere between A and G, with cytology being G.

Q. If now is a good time, if you don't mind short-circuiting it by producing that document now, that would be great.

A. I'm not sure I have it. I thought it was attached to this, but I will do my best to get it for you before tomorrow morning.

Q. Oh, if you can just give it to us tomorrow morning when we start, you don't have to, as long as it doesn't short-circuit my central nervous system.

A. I don't want to short-circuit that.

MR. FOWLER: Okay. Then we'll be okay. Off the record.

(Discussion off the record.)

MR. KLEIN: Let me just put on the record, Mr. Hutton asked whether we had this menu that Dr. Hyers referred to, and it's my understanding -- and other counsel in here can confirm it -- that we have never seen a menu, as the doctor referred to it, attached to he and Dr. Petty's report or, frankly, produced in any other fashion.

MR. WEIL: Well, we certainly haven't seen it attached to the report. It's hard to tell whether it's been produced in any other fashion until we know what it looks like.

MR. KLEIN: Right, but at least anything that was dated or looked that was done contemporaneous with that report, I do not believe anybody has ever seen.

A. It's very similar to what you -- what I have shown you here.

MR. HUTTON: You are talking about Exhibit Number 5?

THE WITNESS: Yes, Exhibit Number 5, but it's a little more developed than Exhibit Number 5. Just give me one minute and let me be sure I don't have it.

MR. HUTTON: I'm just trying to short-circuit everything, too. I don't have it.

(Pause.)

A. No, I don't have it, but I will find it for you.

MR. FOWLER: Okay, thank you, sir.

Why don't we mark this as the next numbered exhibit, please.

(Deposition Exhibit Dr. Hyers 13 marked for identification.)

BY MR. FOWLER:

Q. Would you take a look at Exhibit Number 13 and tell me whether you've seen that before?

A. I don't believe I have.

Q. Why don't you flip to page 9, if you don't mind, sir. Actually, why don't you -- I'm sorry, page 8.

MR. HUTTON: Why don't you explain on the record what this is, so he has some understanding.

MR. FOWLER: That's very acceptable.

BY MR. FOWLER:

Q. Doctor, my understanding of the document that I've handed to you that's been marked Exhibit Number 13, is that these are Plaintiffs' responses to interrogatories, which are written questions that were propounded by the Defendants -- well, Defendant R. J. Reynolds Tobacco Company in this case, so in other

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words, one of the defendants sent Plaintiffs a series of written questions and they responded to those written questions, and that's what you have before you in Exhibit Number 13. Was my explanation understandable?

A. Yes.

Q. Okay. It was dated July 11th, 1997. It says that on the last, on one of the last pages of the document. Oh, and then one last thing: It's simply an excerpt of a longer document. I haven't given you the entire document there, because there's a number of other questions.

Now, Doctor, do you know whether you were consulted in any variety in terms of answering Interrogatory Number 6, which is there at the bottom of page 8?

MR. HUTTON: I would object. He wouldn't know either way. He'd have to jump into the minds of esteemed and prominent counsel from Pennsylvania.

BY MR. FOWLER:

Q. Now that Mr. Hutton has suggested the answer, if you'll given listen carefully, you'll know how to answer the question, Dr. Hyers.

A. You better repeat the question. I'm still not sure I understand it.

Q. Would it be helpful if we repeated the comments of Counsel? No, Doctor, all I want to know is whether, with regard to Interrogatory Number 6, whether you are aware, whether you were consulted in any way in responding to that interrogatory.

MR. HUTTON: Objection.

A. I don't think I was. We finished our expert report in May, and it looks to me like this came out -- I mean, it's dated July 14th, and so we had done our report.

Q. Now, why don't you just take a short look at Response A to Interrogatory 6, there on page 9.

MR. HUTTON: Which is on page 9?

MR. FOWLER: A and B, yes, on page 9.

(Witness peruses said document.)

A. I'm looking at that.

BY MR. FOWLER:

Q. Okay. Now, that lays out, that answer lays out a number of testing methodologies that Plaintiffs' counsel has suggested would be included in the medical monitoring program, including, number 1, an EKG; correct?

A. Correct.

Q. And as you sit here today, you don't know whether that's included in your medical monitoring program; correct?

A. It's not in the document that we've labeled Exhibit 3.

Q. And then we have number 4, an exercise stress test; correct?

A. Correct.

Q. And that's, again, something that you don't recommend in your medical monitoring program; correct?

A. I don't routinely recommend that, no.

Q. And you don't recommend that in your medical monitoring program in this case; correct?

A. Not routinely.

Q. Well, in your report, do you, in your report

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anyplace, say on something other than a routine basis that that procedure is recommended?

A. I'd have to see the document that I'm trying to produce for you but can't find. Again, if, for instance, the EKG were abnormal, one might recommend an exercise stress test, but I don't routinely recommend it.

Q. And you don't know, as you sit here today, whether that's included in your medical monitoring program in this case; correct?

A. I'd have to produce that menu that I've already testified about to answer your question.

Q. And then let's go on to number 6. Number 6 includes the procedures of pulmonary function test, including spirometry, and you recommend only the spirometry and not the other aspects of pulmonary function testing; correct?

A. That is correct.

Q. And regarding number 7, sputum cytology, that's not something that you would routinely recommend. Is that correct, sir?

A. Not in everyone.

Q. And Doctor, you haven't made an assessment, have you, as to what testing methodologies would be appropriate for any of the plaintiffs in this case; correct?

A. I have not assessed the Plaintiffs.

Q. And so in order to make -- well, you'd need to know the Plaintiffs' medical history and other factors about their life style, and so forth, in order to determine what medical monitoring procedures would be appropriate for that person; is that correct?

MR. HUTTON: Objection.

A. I'd have to know more about the Plaintiffs than I do now, yes.

BY MR. FOWLER:

Q. Because that's a uniquely individual assessment, is it not?

MR. HUTTON: Objection.

A.

BY MR. FOWLER:

Q. (Continuing) I mean, in other words, you make decisions concerning what medical monitoring is appropriate on an individual-by-individual basis; correct?

A. As I've already testified, we have a program of medical monitoring, and I'd have to see each individual plaintiff's history and see where that individual fits in.

Q. And of course, it goes without saying but we should say it, that not every smoker in Pennsylvania would be medically monitored under your proposed program; correct?

A. That is correct.

Q. And let me just read to you the class definition in this case as reflected in the Second Amended Complaint that says, "All current residents of Pennsylvania who are cigarette smokers as of December 1, 1996, and who began smoking before age 19 while they were residents of Pennsylvania." Did you understand that?

A. No.

Q. Okay, let me read it again.

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A. I understand the words but I don't understand the context. What is it you are reading? What is the document?

Q. I'm sorry, this is a description of the class of individuals that Plaintiffs hope to include in this class action that's been proposed.

A. Mm-hmm.

Q. In other words, they say that people who should be plaintiffs generally in this lawsuit include -- and I'll quote again -- "All current residents of Pennsylvania who are cigarette smokers as of December 1, 1996, and who began smoking before age 19 while they were residents of Pennsylvania."

Now, Doctor, it's clear from reading that class definition that not all the members of the class would meet the threshold for medical monitoring as you suggested in your report. Isn't that correct?

A. Not for the kind of medical monitoring that we're recommending. Now, if you are asking me if we will advise those individuals to keep smoking if they don't meet our threshold, the answer is no.

Q. No, all I'm asking you, Doctor, is whether all of those individuals would meet the threshold that would require medical monitoring as you propose it in your expert report.

A. They would not, for the kind of medical monitoring that we propose.

Q. Correct.

You know, Doctor, it's about 25 after 4:00, and I promised to get you out of here by 4:30, and this is a good stopping point for me, so if you don't object vigorously, I will cease questioning for today.

A. Thank you.

Q. And you can come back and start again at 8:30 in the morning?

A. 8:30 it is.

MR. FOWLER: Okay, good enough. Thank you, very much, for your attention, Doctor.

(Whereupon, at 4:25 P.M., the deposition was recessed to the following day.)

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